Health and Human Services Commission
Hospital Payment Advisory Committee

February 8, 2018
Meeting Minutes

Members Present:	**Members Absent:**
Diana Strupp, Chair	Phillip Caron
Steve Hand, Vice Chair	Eric Hamon
Bill Bedwell	
Sharon Clark	
Rebecca McCain	
Michael Nunez	
Dan Olvera	
Stephen Kimmel	

1. **Opening Comments: Diana Strupp, Hospital Payment Advisory Committee (HPAC) Chair.**

   Diana Strupp, Hospital Payment Advisory Committee Chair called the meeting to order at 1:30 pm and based upon the members in attendance, a quorum was present.

2. **Approval of November 9, 2017, meeting minutes (Vote required).**

   For the special HPAC meeting minutes:
   Rebecca McCain motioned for approval of the minutes
   Michael Nunez seconded the motion
   The motion to approve the minutes passed unanimously.

   For the regular HPAC meeting minutes:
   Steve Hand motioned for approval of the minutes
   Stephen Kimmel seconded the motion.
   The motion to approve the minutes passed unanimously.

3. **Status of 1115 Demonstration Project extension**

   The 1115 Waiver renewal was approved on December 21, 2017 and is a 5 year renewal, 25 billion dollars all funds. Gary Young noted this is the minimal amount, which could be higher depending on the outcome of negotiations with the Centers for Medicare and Medicaid Services (CMS) on the Uncompensated Care (UC) pool in the three out years of the renewal. Regarding deadlines around the UC; March 30, 2018, is the deadline by which HHSC must send a draft payment protocol to CMS, this is attachment "H" to the Waiver. HHSC has conducted a series of meetings with hospitals and hospital groups to assist

determining what needs to be included in the payment protocol as well as the major concerns of hospitals regarding the draft payment protocol. The proposed UC payment rule is due July 31, 2018. There is a 20% penalty associated with late submission of the draft payment protocol and the UC payment rule. Additionally, CMS has the authority to reduce UC pool expenditures by 20%. January 30, 2019, is the deadline for the final rule to be published. May 1, 2019, is the deadline for submittal to CMS of the UC application. HHSC Executive Commissioner Charles Smith was the lead negotiator on the waiver, in addition HHSC had instrumental help from the Governor's office for the Waiver renewal.

- Gary Young, Special Advisor to the Associate Commissioner, Medicaid and CHIP Services Department, HHSC

Stephen Kimmel voiced concern there exists a significant amount of confusion on the UC program regarding conversion to the S10. Mr. Kimmel asked for clarification.

Monica Leo noted language in STC 33 which indicates in-patient and out-patient UC payments plus Disproportionate Share Hospital (DSH) payments cannot exceed total eligible uncompensated costs. HHSC has requested CMS define if total eligible uncompensated costs means the DSH HSL. HHSC is asking for clarification for hospitals which participate in both DSH and UC, Schedule 3 is DSH HSL. Currently, interim payments are addressed by calculating the amount of payment a hospital would receive in DSH; whatever amount is left over is the Schedule 3 availability for UC. HHSC would like to continue calculating payments in this manner as long as CMS agrees with total eligible uncompensated costs as being a limitation. In STC 33, they mean in-patient and out-patient uninsured charity care payments through UC, and DSH payments can't exceed the DSH HSL, this is currently under review by CMS.

Diana Strupp noted HHSC recently sent a UC protocol survey to hospitals; she requested clarification regarding charity charges as a percentage of a hospital's commercial charges. Ms. Strupp also asked for a definition of commercial charges, whether the term includes all of a hospital's managed care charges or only commercial insurance policies. Bill Bedwell questioned the 100% limit choice in the survey. Ms. Leo stated the questions in the survey were intended to help inform decisions about the requirement in the STCs stating reimbursement has to be based on uncompensated costs and not on the source of the non-Federal share. Ms. Leo noted as example, in Florida CMS approved a tiered system with tiers based on hospital ownership and percentage of UC ratio, defined in Florida as the charity care charges relative to commercial insurance charges. If a hospital has, for example, in excess of 100% of charity relative to commercial insurance, the hospital will be in a tier or pool which will receive reimbursement of a high percentage of uncompensated costs. HHSC seeks the best way to classify hospitals to appropriately make the funding available to the hospitals which are providing the greatest share of eligible uncompensated charity costs.

Michael Nunez stated for the purpose of the commercial insurance definition, he interpreted it to be commercial insurance plus managed care. Rebecca McCain noted it to be managed care as opposed to Medicaid Managed Care. Steve Hand asked if HHSC would consider Worker's Compensation to be Managed Care as he did not. Ms. McCain asked if the definitions in HHSC's 2017 Survey were to be the guideline. Ms. Leo stated the definitions

in the 2017 Survey closely match HHSC's understanding of CMS' intentions; however, the instructions for the S10 are much broader. Ms. Leo agreed the definitions in the American Hospital Association's (AHA) survey of charity care and charity charges look to be very similar to what CMS put forth with regard as to how CMS wants to start shifting reimbursement out of waiver uncompensated care pools. Mr. Nunez asked for clarification on question 11 of the survey, which addressed hospitals completing the survey for the 2017 year. Ms. Leo noted the most recent best information would be appropriate. For purposes of the STC 35, which indicates the State and CMS will collaborate on resizing using information from hospital's S10's for 2017, HHSC has proposed a definition which would be for the hospital fiscal year beginning in calendar year 2017. For resizing, HHSC may be using the hospital year which begins in 2017. Diana Strupp asked for an approximate date when a draft of the UC protocols would be shared with the stakeholders and how it would be distributed. Mr. Young replied it would be shared sometime after February 21, 2018.

INFORMATIONAL ITEMS:

4. Delivery System Reform Incentive Payment Program Demonstration Years 7-8 Amendment

The Texas Health and Human Services Commission proposes amendments to Texas Administrative Code Title 1, Part 15, Chapter 354, Subchapter D, Division 7 rules §354.1691, concerning Definitions; §354.1693, concerning Regional Healthcare Partnerships (RHPs); §354.1695, concerning Participants; §354.1697, concerning RHP Plan Update; §354.1701, concerning RHP Plan Update Modifications; §354.1707, concerning Performer Valuations; §354.1711, concerning Category B Requirements for Performers; §354.1713, concerning Category C Requirements for Performers; §354.1715, concerning Category D Requirements for Performers; §354.1719, concerning Disbursement of Funds; and §354.1721, concerning Remaining Funds for Demonstration Years (DY) 7-8.

- *John Scott, Director of Operations, Texas Healthcare Transformation Waiver, HHSC*

John Scott noted Demonstration Years (DY) 7-8 changes bring Delivery System Reform Incentive Payment (DSRIP) from a project focus to a focus on outcome measures providers select. Provider valuations for DY 7-8 are equal to the valuation for DY6 with a few exceptions; the regional structure of the 20 regional partnerships remains in place. For (DY) 7-8, providers are going through the planning process to submit plan updates to HHSC by April 30, 2018; while defining provider level system, selecting measure bundles and measures to meet minimum point thresholds, establishing calendar year baselines for selected measures and eventually taking steps to improve upon the baselines and will be working to maintain a steady level of service to the waivers target population which is Medicaid, low income and uninsured. As HHSC works with CMS on the protocols, CMS had certain areas where they requested HHSC specifically focus to meet CMS' objectives with the waiver renewal. One of the requests for the final protocols was HHSC strengthen the measurement set. HHSC collaborated with over 100 clinicians on bundle advisory teams to create the measure bundles and measures; CMS requested HHSC to add additional clinical measures and to remove some optional measures and then to make some optional measures required.

HHSC also eliminated the possibility providers would have duplicate measures which was a possibility for certain providers, and added population-based clinical outcomes for hospitals and physician practices. These are clinically focused, they are required for hospitals and physician practices with a point threshold of 75 which is the maximum point threshold. These outcomes focus on specific populations such as people with heart disease, diabetes, children with asthma; clinical measures are worth four points when providers are going through the selection process. At the end of this process of strengthening the measurement set, HHSC ended up with more required measures, but also more available points. In some cases, providers may have an easier time selecting fewer measures because there are more points available for some of the measures, but there are also more required measures.

CMS asked HHSC to define an attribution model and to have all the measure bundles based on a provider's DSRIP attributed population. For hospitals and physician practices the attributed population would, for example, include individuals assigned to a primary care physician, assigned to a clinic or medical home; there are many other qualifying factors for what makes someone part of the attributed population for a provider.

The intent was to make sure no groups were excluded from the pool of accountability for a provider. For example, everyone who comes to the emergency department and everyone who has a preventive visit or an ambulatory visit are qualifying factors to be in the attributed populations. The intent was to cast a wide net to make sure no one was left out of the original pool of accountability at the provider level. From the pool of accountability providers will drill down to the target population within the pool for particular measure.

CMS asked HHSC to revise the limitations for distributing the valuation around category C measures so we previously had a range within which providers could place more money on one particular bundle and remove money from another bundle and make adjustments. CMS was initially skeptical of allowing any variation; however, through discussions, did allow HHSC to keep a range, although the range is narrower than what HHSC originally proposed. A bundle starts out at a standard value based on a formula, a 15-point bundle would be worth more money than a 10-point bundle. The final arrangement was the original value of a bundle could be decreased by 25%, making it 75% of its original value, and bundles with clinical measures could be increased to 125% of the original value, producing a 25% +/- range providers can adjust the valuation for measure bundles. If the valuation changes are more than one percentage point, the provider would give an explanation and justification for the change. An additional change with the measure values is how innovative measures are limited to only 50% of the value of other measures in the bundles. A bundle may have clinical measures and perhaps process measures; if there is an innovative measure, which is not yet rigorously tested or validated, but it's worth studying and gathering data on, those measures are valued at 50% of the value of the other measures in the bundle.

The fourth item CMS requested HHSC review was providers who could already have high baselines. HHSC originally proposed if a provider had a high baseline, they could maintain the baseline to receive their incentive payments; HHSC has done this in demonstration years 2 through 6, where HHSC discovered there were providers who, once they measured their base lines it turned out they were high performing and HHSC had an arrangement to allow the provider to maintain their baseline and do some additional activities to earn their

payments. CMS was troubled providers could select measures they were already doing well; this would not be transformative to the healthcare system. As a result, HHSC has removed the allowance for maintenance of high baselines. Lastly, CMS wanted HHSC to have providers explicitly link core activities to achieve the goals on their measures. As part of their plan when providers select measures and measure bundles, they will be linking an activity to a measure bundle. Drivers and change ideas will be included; this is basically a driver diagram and will be built into the plan template. There were concerns from providers about timeframes; HHSC received the approval January 19th, providers are just submitting their plan updates in April. In response, HHSC accommodated the reduced timeframe by limiting calendar year goals by 50% of what they would have been. With the timeline, plans are due from the regions by the end of April; HHSC will review in May and June and will give final approval June 30th. In July there's a 20% payment for submitting the plan updates so each provider receives 20% of their demonstration year seven valuation in July of 2018. The full reporting period for DY 7 is in October, 2018; the payments would be in January, 2019. The protocols approved were two year protocols so they are demonstration year 7 and 8; HHSC has work to develop protocols for demonstration years 9 and 10 and anticipates the same overall structure. The changes would be around the reduced funding pools for years 9 and 10 and how those funding reductions would be implemented. HHSC will need to develop options and work with stakeholders. HHSC must finalize the DY 9 and 10 protocols and submit to CMS by July 31, 2019. An additional deliverable is the DSRIP transitions plan. DSRIP has the four years of funding and then moves down to zero in year five of the waiver; CMS has required Texas develop a DSRIP transition plan to be submitted by October, 2019, and the transition plan will be much broader than DSRIP, but will be how the lessons learned from DSRIP and the accomplishments of DSRIP are rolled into the future of Texas healthcare. The Medicaid managed care for example, having specific targets for value-based purchasing as part of Medicaid managed care. HHSC already has such targets, and would outline these in the transition plan as well as establishing milestones for the state to achieve in the transition plan; these would be milestones for Texas as a whole, the State Medicaid Program and not for specific providers. CMS has indicated they wish to work with HHSC on the transition plan and has proposed to meet this spring with the transition plan submission in October, 2019.

Michael Nunez questioned the submission of the RHP, asking if the plan were to be submitted by the end of February, would it be included in the April reporting with payment to be received in July, 2018, meaning payment would be received six months early.

John Scott replied yes, there is some additional time required for HHSC to review the plan updates once they're submitted and ask for additional information if needed. If HHSC anchors are able to submit their updates by the end of February, 2018, HHSC would do an expedited review of those plan updates by the end of March, 2018, so providers in the regions could do DY7 reporting in April, 2018; what they would possibly report are their category C baselines.

Bill Bedwell questioned if HHSC has completed negotiations with CMS and if all that remains is implementation. John Scott replied, for DY 7 and 8 HHSC is finished negotiating with CMS and everything is approved, all of the work for DY 7 & 8 is complete.

Gary Young commented the work John Scott and his team did was tremendous and HHSC would not have been allowed to draw down DSRIP funding had the January 19, 2018, deadline not been met. Rebecca McCain recommended HHSC communicate to the providers the RHP plan updates have to come from the RHP; the providers are to submit RHP plan templates to the anchors and the anchors will submit them.

Diana Strupp thanked John Scott for his presentation. Miss Strupp also thanked HHSC on behalf of the HPAC committee for the work on the waiver renewal.

Michael Nunez asked for an update on the timing perspective of the Schedule 3 discussion as a deliverable from the November, 2017, HPAC meeting. Rene Cantu, HHSC Rate Analysis for Hospitals stated the information for the DY2 reconciliation has been reviewed; there are a couple of outstanding items. Once the information is finalized HHSC will be able to provide a report. Bill Bedwell asked if HHSC is waiting for information from hospitals, is there anything the HPAC can do to expedite this. Mr. Cantu replied there are a couple of issues which were expected to be resolved. Once the information is complete a report will be provided to the committee.

5. Public comment

No additional Public Comment was received.

6. Proposed next meeting: May 10, 2018, at 1:30 p.m.

7. Meeting Adjourned.